LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

CHIEF INFORMATION OFFICE BUREAU

TRADING PARTNER AGREEMENT REQUEST APPLICATION ACCESS FORM

This form ONLY applies to TPA Request Application.
This form is intended for users that do NOT have an Integrated System (IS) login user name and password.

APPLICANT INFORMATION

Select one: ☐ Legal Entity ☐ Network Provider		
First Name:	Last Name:	MI:
Last 4 digits of SSN:	Month and Day of Birth (MM/DD):	
Legal Entity / Network Provider Name:		
Legal Entity / Billing Provider Number:		
Address:		
City:	State:	Zip Code:
Telephone Number:	E-mail Address:	

SIGNATURES

Applicant Print Name: Date:	Signature
Authorized Designee Print Name: Date:	Signature

FOR OFFICIAL USE ONLY
To be completed by DMH Chief Information Office Bureau (CIOB).

Approved By:	Date Approved:
Completed By:	Date Completed:
User ID:	

Please sign, scan and e-mail this form to: Department of Mental Health
CIOB – Integration Unit: TPA@dmh.lacounty.gov
A confirmation will be sent to the e-mail listed in this application.